FOR OHF USE

LL1

2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0044073

Facility Name: Heritage Manor-Mount Zion

Address: 1225 WOODLAND DRIVE (Number) Mt. Zion (City) 61701 (Zip Code)

County: Macon

Telephone Number: (217) 864-2356 **Fax #** ( )

IDPA ID Number: 370909086024

Date of Initial License for Current Owners: 10/01/98

Type of Ownership:

	VOLUNTARY,NON-PROFIT	xx	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		xx	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: CRAIG L. ATER **Telephone Number:** ( )

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/01/2002 to 12/31/2002 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) CRAIG L. ATER

(Title) Senior Vice President -- Finance

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) (309)823-7135 Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Heritage Manor-Mount Zion # 0044073 Report Period Beginning: 1/01/2002 Ending: 12/31/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	75	Skilled (SNF)	75	27,375	1
2		Skilled Pediatric (SNF/PED)			2
3	0	Intermediate (ICF)	0	0	3
4		Intermediate/DD			4
5	0	Sheltered Care (SC)	0	0	5
6		ICF/DD 16 or Less			6
7	75	TOTALS	75	27,375	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	16,930	3,313	2,568	22,811	8
9	SNF/PED			0		9
10	ICF					10
11	ICF/DD					11
12	SC	0	0	0		12
13	DD 16 OR LESS					13
14	TOTALS	16,930	3,313	2,568	22,811	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.33%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [XX]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [XX]

I. On what date did you start providing long term care at this location?
Date started 10/01/98

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date 10/01/98 NO [xx]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [xx] If YES, enter number of beds certified _____ and days of care provided 2,568

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [XX] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [XX] NO [ ]

Tax Year: _____ Fiscal Year: _____

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Heritage Manor-Mount Zion # 0044073 **Report Period Beginning:** 1/01/2002 **Ending:** 12/31/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	A. General Services											
1	Dietary	133,930	11,987		145,917		145,917	2,570	148,487			1
2	Food Purchase		104,662		104,662		104,662	(857)	103,805			2
3	Housekeeping	65,816	9,469		75,285		75,285		75,285			3
4	Laundry	25,912	9,799		35,711		35,711		35,711			4
5	Heat and Other Utilities			78,666	78,666		78,666	799	79,465			5
6	Maintenance	29,292	25,051	12,894	67,237		67,237	6,915	74,152			6
7	Other (specify):*											7
8	**TOTAL General Services**	254,950	160,968	91,560	507,478		507,478	9,427	516,905			8
	B. Health Care and Programs											
9	Medical Director			19,500	19,500		19,500		19,500			9
10	Nursing and Medical Records	795,826	65,403	159,722	1,020,951		1,020,951		1,020,951			10
10a	Therapy		137,223	123,148	260,371	(283,756)	(23,385)	133,748	110,363			10a
11	Activities	18,960	1,767		20,727		20,727		20,727			11
12	Social Services	20,922		2,374	23,296		23,296		23,296			12
13	Nurse Aide Training	2,349	798		3,147		3,147	1,429	4,576			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	838,057	205,191	304,744	1,347,992	(283,756)	1,064,236	135,177	1,199,413			16
	C. General Administration											
17	Administrative	53,000			53,000		53,000	66,413	119,413			17
18	Directors Fees							3,525	3,525			18
19	Professional Services			169,938	169,938		169,938	(163,302)	6,636			19
20	Dues, Fees, Subscriptions & Promotions			67,463	67,463	(41,062)	26,401	(4,056)	22,345			20
21	Clerical & General Office Expenses	70,741	8,690	13,368	92,799		92,799	139,692	232,491			21
22	Employee Benefits & Payroll Taxes			191,504	191,504		191,504	18,266	209,770			22
23	Inservice Training & Education			1,425	1,425		1,425	574	1,999			23
24	Travel and Seminar			6,432	6,432		6,432	(4,433)	1,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			28,431	28,431		28,431	1,345	29,776			26
27	Other (specify):*			36,361	36,361		36,361	(36,025)	336			27
28	**TOTAL General Administration**	123,741	8,690	514,922	647,353	(41,062)	606,291	21,999	628,290			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,216,748	374,849	911,226	2,502,823	(324,818)	2,178,005	166,603	2,344,608			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Heritage Manor-Mount Zion #0044073 Report Period Beginning: 1/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			192,403	192,403		192,403	6,563	198,966			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			133,122	133,122		133,122	(364)	132,758			32
33	Real Estate Taxes			58,000	58,000		58,000		58,000			33
34	Rent-Facility & Grounds							5,040	5,040			34
35	Rent-Equipment & Vehicles			6,337	6,337		6,337	8,796	15,133			35
36	Other (specify):*											36
37	**TOTAL Ownership**			389,862	389,862		389,862	20,035	409,897			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					283,756	283,756		283,756			39
40	Barber and Beauty Shops			7,311	7,311		7,311		7,311			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					41,062	41,062		41,062			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			7,311	7,311	324,818	332,129		332,129			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,216,748	374,849	1,308,399	2,899,996		2,899,996	186,638	3,086,634			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Heritage Manor-Mount Zion # 0044073 Report Period Beginning: 1/01/2002 Ending: 12/31/2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(1,173)	35		5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		30		9
10	Interest and Other Investment Income	(529)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(857)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions		33		15
16	Personal Expenses (Including Transportation)		24		16
17	Non-Care Related Fees	(360)	20		17
18	Fines and Penalties				18
19	Entertainment	(8,897)	24		19
20	Contributions	(25)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(6,676)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(36,000)	27		24
25	Fund Raising, Advertising and Promotional	(6,429)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Real estate taxes		33		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (60,946)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	247,584		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 247,584		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 186,638		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Heritage Manor-Mount Zion

ID# **0044073**

Report Period Beginning: **1/01/2002**

Ending: **12/31/2002**

	NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1		$	0	0	1
2			0	0	2
3			0	0	3
4			0	0	4
5			(1,173)	35	5
6			0	34	6
7			0		7
8			0		8
9			0	30	9
10				32	10
11			0		11
12			0		12
13			(857)	2	13
14			0	32	14
15			0	33	15
16			0	24	16
17			(360)	20	17
18			0		18
19				24	19
20			(25)	27	20
21			0		21
22			(6,676)	19	22
23			0		23
24			(36,000)	27	24
25			(6,429)	20	25
26			0	0	26
27			0	0	27
28			0	0	28
29			0	0	29
30			0	0	30
31			0	0	31
32					32
33			0	33	33
34					34
35					35
36					36
37					37
38					38
39					39
40					40
41					41
42					42
43					43
44					44
45					45
46					46
47					47
48					48
49	**Total**		(51,520)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Manor-Mount Zion **#** 0044073 **Report Period Beginning:** 1/01/2002 **Ending:** 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	2,570	0	0	0	0	0	0	0	0	2,570	1
2	Food Purchase	(857)	0	0	0	0	0	0	0	0	0	0	(857)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	799	0	0	0	0	0	0	0	0	799	5
6	Maintenance	0	0	6,915	0	0	0	0	0	0	0	0	6,915	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(857)	0	10,284	0	0	0	0	0	0	0	0	9,427	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	133,748	0	0	0	0	0	0	0	0	0	133,748	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	1,429	0	0	0	0	0	0	0	0	1,429	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	133,748	1,429	0	0	0	0	0	0	0	0	135,177	16
	C. General Administration													
17	Administrative	0	0	66,413	0	0	0	0	0	0	0	0	66,413	17
18	Directors Fees	0	0	3,525	0	0	0	0	0	0	0	0	3,525	18
19	Professional Services	(6,676)	(163,262)	6,636	0	0	0	0	0	0	0	0	(163,302)	19
20	Fees, Subscriptions & Promotions	(6,789)	0	2,733	0	0	0	0	0	0	0	0	(4,056)	20
21	Clerical & General Office Expenses	0	0	139,692	0	0	0	0	0	0	0	0	139,692	21
22	Employee Benefits & Payroll Taxes	0	0	18,266	0	0	0	0	0	0	0	0	18,266	22
23	Inservice Training & Education	0	0	574	0	0	0	0	0	0	0	0	574	23
24	Travel and Seminar	(8,897)	0	4,464	0	0	0	0	0	0	0	0	(4,433)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,345	0	0	0	0	0	0	0	0	1,345	26
27	Other (specify):*	(36,025)	0	0	0	0	0	0	0	0	0	0	(36,025)	27
28	**TOTAL General Administration**	(58,387)	(163,262)	243,648	0	0	0	0	0	0	0	0	21,999	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(59,244)	(29,514)	255,361	0	0	0	0	0	0	0	0	166,603	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Heritage Manor-Mount Zion** **# 0044073** **Report Period Beginning:** **1/01/2002** **Ending:** **12/31/2002**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	6,563	0	0	0	0	0	0	0	6,563	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(529)	0	0	165	0	0	0	0	0	0	0	(364)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	5,040	0	0	0	0	0	0	0	5,040	34
35	Rent-Equipment & Vehicles	(1,173)	0	0	9,969	0	0	0	0	0	0	0	8,796	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(1,702)	0	0	21,737	0	0	0	0	0	0	0	20,035	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(60,946)	(29,514)	255,361	21,737	0	0	0	0	0	0	0	186,638	45

Facility Name & ID Number Heritage Manor-Mount Zion # 0044073 Report Period Beginning: 1/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V	10a	Adjustment for Related Organization	122,584	GreenTree Therapy	100.00%	108,481	(14,103)	2
3	V								3
4	V	19	Adjustment for Related Organization	163,262	Heritage Enterprises, Inc.	100.00%		(163,262)	4
5	V								5
6	V	10a	Adjustment for Related Organization	137,295	GreenTree Pharmacy	100.00%	285,146	147,851	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 423,141			$ 393,627	$ * (29,514)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Heritage Manor-Mount Zion # 0044073 Report Period Beginning: 1/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	$	Heritage Enterprises, Inc.	100.00%	$ 2,570	$ 2,570	15
16	V	2	Food Purchase				0		16
17	V	3	Housekeeping				0		17
18	V	4	Laundry				0		18
19	V	5	Heat & Other Utilities				799	799	19
20	V	6	Maintenance				6,915	6,915	20
21	V	7	Other				0		21
22	V	9	Medical Director				0		22
23	V	10	Nursing & Medical Records				0		23
24	V	11	Activities				0		24
25	V	12	Social Service				0		25
26	V	13	Nurse Aide Training				1,429	1,429	26
27	V	14	Program Transportation				0		27
28	V	15	Other				0		28
29	V	17	Administrative				66,413	66,413	29
30	V	18	Directors Fees				3,525	3,525	30
31	V	19	Professional Services				6,636	6,636	31
32	V	20	Fees, Subscription, Promotions				2,733	2,733	32
33	V	21	Clerical & General Office Expenses				139,692	139,692	33
34	V	22	Employee Benefits & Payroll Taxes				18,266	18,266	34
35	V	23	Inservice Training & Education				574	574	35
36	V	24	Travel and Seminar				4,464	4,464	36
37	V	25	Other Admin. Staff Transportation				0		37
38	V	26	Insurance-Prop.Liab.Malpract				1,345	1,345	38
39	Total			$			$ 255,361	$ * 255,361	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Heritage Manor-Mount Zion # 0044073 Report Period Beginning: 1/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	27	Other	$	Heritage Enterprises, Inc.	100.00%	$ 0	$	15
16	V	30	Depreciation				6,563	6,563	16
17	V	31	Amortization of Pre-Op & Org				0		17
18	V	32	Interest				165	165	18
19	V	33	Real Estate Taxes				0		19
20	V	34	Rent-Facility & Grounds				5,040	5,040	20
21	V	35	Rent-Equipment & Vehicles				9,969	9,969	21
22	V	36	Other				0		22
23	V	38	Medically Nec Transportation				0		23
24	V	39	Ancillary Service Centers				0		24
25	V	40	Barber and Beauty Shops				0		25
26	V	41	Coffee and Gift Shops				0		26
27	V	42	Other				0		27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 21,737	$ * 21,737	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Heritage Manor-Mount Zion # 0044073 Report Period Beginning: 1/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week Hours	Percent	Compensation Included in Costs for this Reporting Period** Description	Amount	Schedule V. Line & Column Reference	
1	Bill Froelich	Chairman of Board	Management	26.00	397,396	5	100.00	Director/Salary	$ 12,414	line 17/18, col	1
2	Tom Jefferson	Asst Secretary/Treas	Management	10.00	390,860	5	100.00	Director/Salary	12,209	line 17/18, col	2
3	Craig Hart	Secretary/Treasurer	Management	20.00	343,058	10	100.00	Director/Salary	10,716	line 17/18, col	3
4	Joe Warner	President	Management	2.50	370,366	40	100.00	Director/Salary	11,569	line 17/18, col	4
5	Bob Dickson	Executive Vice Presid	Management	0.80	92,266	40	100.00	Salary	2,882	line 17, col 7	5
6	Cheryl Lowney	Executive Vice Presid	Management	0.30	186,564	50	100.00	Director/Salary	5,828	line 17/18, col	6
7	Steve Wannemacher	Executive Vice Presid	Management	0.30	175,068	50	100.00	Director/Salary	5,469	line 17/18, col	7
8	Connie Hoselton	Sr Vice President	Management	0.17	140,191	40	100.00	Salary	4,379	line 17, col 7	8
9	Craig Ater	Sr Vice President	Management	0.21	143,176	50	100.00	Salary	4,472	line 17, col 7	9
10											10
11											11
12											12
13								TOTAL	$ 69,938		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Heritage Manor-Mount Zion # 0044073 Report Period Beginning: 1/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [xx]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Beds	2,401	24	$ 82,266	$ 82,266	75	$ 2,570	1
2	2	Food Purchase	Beds	2,401	24	0	0	75	0	2
3	3	Housekeeping	Beds	2,401	24	0	0	75	0	3
4	4	Laundry	Beds	2,401	24	0	0	75	0	4
5	5	Heat & Other Utilities	Beds	2,401	24	25,593	0	75	799	5
6	6	Maintenance	Beds	2,401	24	221,381	58,785	75	6,915	6
7	7	Other	Beds	2,401	24	0	0	75	0	7
8	9	Medical Director	Beds	2,401	24	0	0	75	0	8
9	10	Nursing & Medical Records	Beds	2,401	24	0	0	75	0	9
10	11	Activities	Beds	2,401	24	0	0	75	0	10
11	12	Social Service	Beds	2,401	24	0	0	75	0	11
12	13	Nurse Aide Training	Beds	2,401	24	45,737	39,267	75	1,429	12
13	14	Program Transportation	Beds	2,401	24	0	0	75	0	13
14	15	Other	Beds	2,401	24	0	0	75	0	14
15	17	Administrative	Beds	2,401	24	2,126,096	2,126,096	75	66,413	15
16	18	Directors Fees	Beds	2,401	24	112,849	0	75	3,525	16
17	19	Professional Services	Beds	2,401	24	212,454	0	75	6,636	17
18	20	Fees, Subscription, Promotions	Beds	2,401	24	87,500	0	75	2,733	18
19	21	Clerical & General Office Expens	Beds	2,401	24	4,472,002	4,183,145	75	139,692	19
20	22	Employee Benefits & Payroll Taxe	Beds	2,401	24	584,769	0	75	18,266	20
21	23	Inservice Training & Education	Beds	2,401	24	18,362	0	75	574	21
22	24	Travel and Seminar	Beds	2,401	24	142,902	0	75	4,464	22
23	25	Other Admin. Staff Transportatio	Beds	2,401	24	0	0	75	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,401	24	43,070	0	75	1,345	24
25	TOTALS					$ 8,174,981	$ 6,489,559		$ 255,361	25

Facility Name & ID Number Heritage Manor-Mount Zion # 0044073 Report Period Beginning: 1/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	27	Other	Beds	2,401	24	$	$	75	$	1
2	30	Depreciation	Beds	2,401	24	210,090		75	6,563	2
3	31	Amortization of Pre-Op & Org	Beds	2,401	24			75		3
4	32	Interest	Beds	2,401	24	5,270		75	165	4
5	33	Real Estate Taxes	Beds	2,401	24			75		5
6	34	Rent-Facility & Grounds	Beds	2,401	24	161,349		75	5,040	6
7	35	Rent-Equipment & Vehicles	Beds	2,401	24	319,142		75	9,969	7
8	36	Other	Beds	2,401	24			75		8
9	38	Medically Nec Transportation	Beds	2,401	24			75		9
10	39	Ancillary Service Centers	Beds	2,401	24			75		10
11	40	Barber and Beauty Shops	Beds	2,401	24			75		11
12	41	Coffee and Gift Shops	Beds	2,401	24			75		12
13	42	Other	Beds	2,401	24			75		13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 695,851	$		$ 21,737	25

Facility Name & ID Number Heritage Manor-Mount Zion # 0044073 Report Period Beginning: 1/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	LaSalle National Bank		XX	Mortage	$22,274.00	01/26/01	$ 3,017,866	$ 2,844,830	01/15/06	variable	$ 116,067	1
2	Loan Amortization		XX	Mortgage							4,571	2
3	Central Office Allocation		XX	Interest Income								3
4												4
5												5
	Working Capital											
6	Central Office Allocation		xx	Working Capital							12,484	6
7	Central Office Allocation		xx	Working Capital							165	7
8												8
9	TOTAL Facility Related				$22,274.00		$ 3,017,866	$ 2,844,830			$ 133,287	9
	B. Non-Facility Related*											
10	Interest Income										(529)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (529)	14
15	TOTALS (line 9+line14)						$ 3,017,866	$ 2,844,830			$ 132,758	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Heritage Manor-Mount Zion # 0044073 **Report Period Beginning:** 1/01/2002 **Ending:** 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	61,905	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	58,490	2
3. Under or (over) accrual (line 2 minus line 1).	$	(3,415)	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)	$	61,415	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	58,000	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1997		8
1998		9
1999		10
2000		11
2001		12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heritage Manor-Mount Zion COUNTY Macon

FACILITY IDPH LICENSE NUMBER 0044073

CONTACT PERSON REGARDING THIS REPORT Craig Ater

TELEPHONE (309)823-7135 FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	121704210003	Nursing Home	$ 58,490.00	$ 58,490.00
2.		Nursing Home	$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 58,490.00	$ 58,490.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number Heritage Manor-Mount Zion # 0044073 Report Period Beginning: 1/01/2002 Ending: 12/31/2002

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 33,800 B. General Construction Type: Exterior Brick/Wood Frame _____ Number of Stories _____

C. Does the Operating Entity? [xx] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [xx] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [xx] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Land			$ 50,000	1
2					2
3	TOTALS			$ 50,000	3

Facility Name & ID Number Heritage Manor-Mount Zion # 0044073 Report Period Beginning: 1/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	75				$ 1,076,000	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Environmental Site Study			1998	1,662						9
10	Sign			1998	1,860						10
11	Air conditioning Unit			1999	5,732						11
12	Air Conditioner			1999	750						12
13	Professional Fees --Remodeling Project			1999	15,922						13
14											14
15	Facility Remodel -- Materials			2000	241,637						15
16	Professional Fees --Remodeling Project			2000	58,519						16
17	Kitchen A/C			2000	990						17
18	Fire Alarm			2000	1,997						18
19	Door Guard System			2000	3,444						19
20											20
21	Smoke Detectors			2001	3,775						21
22	Water Main Break			2001	3,426						22
23	Commercial Disposer			2001	757						23
24	Heat Pump			2001	5,158						24
25	Carpet Extract			2001	1,206						25
26				2001							26
27	Facility Remodel -- Contractor			2001	1,397,646						27
28	Professional Fees --Remodeling Project			2001	45,077						28
29											29
30	Facility Remodel -- Contractor			2002	2,762						30
31	Fire Dampers			2002	2,766						31
32											32
33											33
34	C/O Allocation							6,563	6,563		34
35	Book Depreciation					145,153		145,153		284,688	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Heritage Manor-Mount Zion # 0044073 Report Period Beginning: 1/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,871,086	$ 145,153		$ 151,716	$ 6,563	$ 284,688	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Heritage Manor-Mount Zion # 0044073 Report Period Beginning: 1/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,871,086	$ 145,153		$ 151,716	$ 6,563	$ 284,688	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,871,086	$ 145,153		$ 151,716	$ 6,563	$ 284,688	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Heritage Manor-Mount Zion # 0044073 Report Period Beginning: 1/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 330,632	$ 47,250	$ 47,250	$		$ 157,161	71
72	Current Year Purchases	10,906						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 341,538	$ 47,250	$ 47,250	$		$ 157,161	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,262,624	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 192,403	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 198,966	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 6,563	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 441,849	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 15,133 Description: pager, computer equipment
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Heritage Manor-Mount Zion # 0044073 Report Period Beginning: 1/01/2002 Ending: 12/31/2002

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? ☐ YES ☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM ☐
- IN OTHER FACILITY ☐
- COMMUNITY COLLEGE ☐
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM ☐
- IN OTHER FACILITY ☐
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies		798		798
3	Classroom Wages (a)		2,349		2,349
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$ 3,147	$	$ 3,147
10	SUM OF line 9, col. 1 and 2 (e)	$ 3,147			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a/3	hrs	$		$ 44,589	$		$ 44,589	1
2	Licensed Speech and Language Development Therapist	10a/3	hrs			7,533			7,533	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a/3	hrs			56,359	1,882		58,241	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39/3	# of prescrpts				283,192		283,192	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): x-ray	39/3				564			564	13
14	TOTAL			$		$ 109,045	$ 285,074		$ 394,119	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Heritage Manor-Mount Zion **#** 0044073 **Report Period Beginning:** 1/01/2002 **Ending:** 12/31/2002

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2002 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 7,269	$	1
2	Cash-Patient Deposits	16,862		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	309,341		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	367		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(1,061,695)		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ (727,856)	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	50,000		13
14	Buildings, at Historical Cost	2,871,087		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	341,538		16
17	Accumulated Depreciation (book methods)	(441,849)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Deferred Tax Asset	14,094		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,834,870	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,107,014	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 42,902	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	16,862		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	111,757		30
31	Accrued Taxes Payable (excluding real estate taxes)	3,432		31
32	Accrued Real Estate Taxes(Sch.IX-B)	61,415		32
33	Accrued Interest Payable	8,547		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Security Deposits	10,350		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 255,265	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	2,844,830		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,844,830	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,100,095	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (993,081)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,107,014	$	48

***(See instructions.)**

Facility Name & ID Number Heritage Manor-Mount Zion # 0044073 Report Period Beginning: 1/01/2002 Ending: 12/31/2002

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (709,181)	1
2	Restatements (describe):		2
3	**Audit Adjustment**		3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (709,181)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(283,900)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (283,900)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (993,081)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Heritage Manor-Mount Zion # 0044073 Report Period Beginning: 1/01/2002 Ending: 12/31/2002

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,637,764	1
2	Discounts and Allowances for all Levels	(501,372)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,136,392	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	234,719	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 234,719	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	1,690	12
13	Barber and Beauty Care	6,774	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	235,748	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	244	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 244,456	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	529	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 529	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,616,096	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	507,478	31
32	Health Care	1,347,992	32
33	General Administration	647,353	33
	B. Capital Expense		
34	Ownership	389,862	34
	C. Ancillary Expense		
35	Special Cost Centers	7,311	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37	Loss from Non-Nursing property		37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,899,996	40
41	**Income before Income Taxes (line 30 minus line 40)****	(283,900)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (283,900)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Heritage Manor-Mount Zion # 0044073 Report Period Beginning: 1/01/2002 Ending: 12/31/2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,952	2,188	$ 38,572	$ 17.63	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	5,702	6,245	117,351	18.79	3
4	Licensed Practical Nurses	11,559	12,194	192,702	15.80	4
5	Nurse Aides & Orderlies	40,989	43,489	387,823	8.92	5
6	Nurse Aide Trainees	303	303	2,349	7.75	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,319	4,694	59,378	12.65	8
9	Activity Director					9
10	Activity Assistants	2,114	2,305	18,960	8.23	10
11	Social Service Workers	1,705	2,093	20,922	10.00	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,229	17,460	133,930	7.67	15
16	Dishwashers					16
17	Maintenance Workers	2,710	2,988	29,292	9.80	17
18	Housekeepers	9,166	9,464	65,816	6.95	18
19	Laundry	3,463	3,675	25,912	7.05	19
20	Administrator	2,080	2,080	53,000	25.48	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,850	5,494	70,741	12.88	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	107,141	114,672	$ 1,216,748 *	$ 10.61	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 0		35
36	Medical Director		19,500		36
37	Medical Records Consultant		1,400		37
38	Nurse Consultant				38
39	Pharmacist Consultant		2,040		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		2,374		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 25,314		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 5,007		50
51	Licensed Practical Nurses		38,753		51
52	Nurse Aides		112,253		52
53	TOTAL (lines 50 - 52)		$ 156,013		53

Facility Name & ID Number Heritage Manor-Mount Zion # 0044073 Report Period Beginning: 1/01/2002 Ending: 12/31/2002

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Barb Re	Administrator	0	$ 53,000
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 53,000

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Heritage Enterprises	Management Fees	$ 163,262
		0
		0
		0
Legal Fees (Adjusted to zero)		6,676
		0
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 169,938

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 24,246
Unemployment Compensation Insurance	15,444
FICA Taxes	93,081
Employee Health Insurance	50,424
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Hepatitis Vaccine	426
Employee Benefits -	7,883
Employee Benefits - central office	18,266
TOTAL (agree to Schedule V, line 22, col.8)	$ 209,770

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	13,218
Health Care Worker Background Check	
(Indicate # of checks performed 14)	364
Central Office Allocation	2,733
Promotional Advertising	3,610
Public Relations	2,819
Dues and Subscriptions	5,679
License and Fees	511
Less: Public Relations Expense	(2,819)
Non-allowable advertising	(360)
Yellow page advertising	(3,610)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 22,345

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	4,925
	133
Seminar Expense	1,374
Non Allowable	(8,897)
Central Office Allocation	4,464
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,999

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Heritage Manor-Mount Zion # 0044073 Report Period Beginning: 1/01/2002 Ending: 12/31/2002

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Heritage Manor-Mount Zion **#** 0044073 **Report Period Beginning:** 1/01/2002 **Ending:** 12/31/2002

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **no**

(2) Are there any dues to nursing home associations included on the cost report? **yes**
If YES, give association name and amount. **Illinois Healthcare Association**

(3) Did the nursing home make political contributions or payments to a political action organization? **no** If YES, have these costs been properly adjusted out of the cost report? **yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **no** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **yes**
What was the average life used for new equipment added during this period? **7 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **5,000** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **no**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **xx** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **no** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **41,062**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **no** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **no** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **yes** Indicate the amount. $ **313**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **no**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **no** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100**
d. Have vehicle usage logs been maintained? **yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **yes**
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **yes**
Firm Name: **Sulaski & Webb** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Not available at this date**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **yes**
Attach invoices and a summary of services for all architect and appraisal fees.

Account Number			Description	G/L Balance	Cost Rpt Grouping	Sch 5 pg 3/4 Line #	Sch 5 pg 3/4 Col #	Sch 6 pg 5 Line #	Adjustment Amount				
1009			PETTY CASH	7,269							1,009	1,009 PETTY CA	7,269
1010			CASH IN BANK								1,100	1,100 ACCTS RE	309,341
1040			CASH IN BANK-PAYROLL								1,101	1,101 ALLOW. FOR UNCOLLECTIBLES	
1100			ACCOUNTS RECEIVABLE	309,341							1,110	1,110 ACCTS RECEIV-M/C	
1110			MEDICARE RECEIVABLES								1,125	1,125 ACCTS RECEIV-IPA	
1125			IPA INCOME RECEIVABLE								1,135	1,135 ACCTS RECEIV-IC	
1130			MEDICARE COST REPORT								1,140	1,140 UNAPPLIED CASH RECEIPTS	
1135			ACCOUNTS RECEIVABLE-IC								1,145	1,145 A/R SUSPENSE-REFUNDS	
1140			UNAPPLIED CASH RECEIPTS								1,200	1,200 PREPAID I	367
1145			A/R SUSPENSE-REFUNDS								1,220	1,220 OTHER PREPAID EXPENSES	
1190			ACCRUED INTEREST REC								1,300	1,300 DIETARY INVENTORY	
1200			PREPAID INSURANCE	367							1,310	1,310 SUPPLIES INVENTORY	
1220			OTHER PREPAID EXPENSES								1,320	1,320 LINEN INVENTORY	
1300			FOOD INVENTORY								1,409	1,409 LAND	50,000
1310			SUPPLIES INVENTORY								1,450	1,450 FURNITUR	341,538
1409			LAND	50,000							1,460		-157,161
1450			FURNITURE & EQUIPMENT	341,538							1,475	1,475 CODE ALE	2,871,087
1460			ACCUM DEPR-FURN & EQUIP	-157,161							1,490	1,490 ACCUM D	-284,688
1475			BUILDING & IMPROVEMENTS	2,871,087							1,530	1,530 RESIDENT	16,862
1490			ACCUM DEPR-BUILDING	-284,688							1,550	1,550 LOAN FEE	14,094
1530			RESIDENT FUNDS	16,862							1,551	1,551 LOAN FEES ADDED	
1550			LOAN FEES	14,094							1,850	1,850 INTERCOM	-1,061,695
1560			REAL ESTATE TAX ESCROW								2,010	2,010 ACCOUNT	-42,902
1575			REIMBURSABLE PURCHASES								2,100	2,095 BONUSES PAYABLE	
1850			INTRACOMPANY	-1,061,695							2,100	2,100 ACCRUED	-70,376
2010			ACCOUNTS PAYABLE	-42,902							2,100	2,100 PR CLEARING-BENEFITS	
2095			BONUSES PAYABLE								2,100	2,100 PR CLEARING-LABOR	
2100			ACCRUED PAYROLL	-70,376							2,110	2,110 ACCRUED	-41,381
2110			ACCRUED VACATION PAY	-41,381							2,120	2,120 U.C. TAXES PAYABLE	
2120			UC TAXES PAYABLE								2,125	2,125 FICA TAXI	-3,432
2125			FICA TAX PAYABLE	-3,432	-3,432						2,130	2,130 FEDERAL W/H TAX PAYABLE	
2130			FIT PAYABLE								2,140	2,140 STATE W/H TAX PAYABLE	
2140			STATE W/H PAYABLE		0						2,152	2,152 WORKERS COMP ACCRUAL	
2145			EARNED INCOME CREDIT								2,225	2,225 EMPLOYEEE INSURANCE REFUND	
2150			UC FED CREDIT REDUCTION								2,230	2,230 PAYROLL SAVINGS	
2230			PAYROLL SAVINGS								2,235	2,240 UNITED FUND	
2235			IRA W/HOLDINGS								2,240	2,246 GROUP INSURANCE - CAFETERIA	
2240			UNITED WAY								2,246	2,250 401K W/H	
2245			GROUP INSURANCE PAYABLE								2,250		
2246			GROUP INSURANCE PAYABLE-CAFETERIA								2,260	2,260 WAGE GARNISHMENT	
2260			WAGE GARNISHMENTS								2,300	2,300 ACCRUED	-8,547
2280			MISC PAYROLL DEDUCTIONS								2,320	2,320 IPA PAYM	-10,350
2300			ACCRUED INTEREST PAYABLE	-8,547							2,350	2,350 REAL EST.	-61,415
2310			SALES TAX PAYABLE								2,385		
2320			IPA PAYMENTS PAYABLE	-10,350							2,400	2,400 CURRENT PORTION OF LT DEBT	
2350			REAL ESTATE TAX PAYABLE	-61,415							2,512	2,512 DUE TO RI	-16,862
2385			ACTIVITY FUND	0							2,600	2,600 LASALLE	-2,844,830
2390			SECURITY DEPOSITS								2,600		
2391			VOLUNTEER FUND								2,625	2,625 LASALLE	0
2393			HEART FUND/BAZAAR								2,625		
2395			DEFERRED INC EMP & MEM								2,695	2,695 CURRENT PORTION OF LT DEBT	
2400			CURRENT PORTION LT DEBT								2,720	2,720 RETAINED	709,181
2460			INCOME TAXES PAYABLE									net income	283,900
2512			DUE TO RESIDENTS	-16,862									
2600			MORTGAGE PAYABLE	-2,844,830									
2650			EQUIPMENT LOAN PAYABLE									balance	0
2695			CURRENT PORTION LT DEBT										
2696			DEFERRED INCOME TAXES										
2710			COMMON STOCK										
2720			RETAINED EARNINGS	709,181									
2970			PROFIT/LOSS FOR PERIOD	283,900									
3007.1			PATIENT DAYS-PRIVATE	3,496							3,007	3,007 PATIENT I	3,496
3007.2			PATIENT DAYS-IPA	16,937							3,007	3,007 PATIENT I	16,937
3007.3			PATIENT DAYS-MEDICARE	2,568							3,007	3,007 PATIENT I	2,568
3007.4			PATIENT DAYS-CONVERSION								3,007		
3007.5			PATIENT DAYS-LICENSED								3,007		
3007.6			PATIENT DAYS-TOTAL								3,007		
3010		1	BASIC CHARGE-PRIVATE & VA	-386,783		0	0	0	0		3,007		
3015		1	PRIVATE ASSESSMENT TAX INCOME			0	0	0	0		3,010	3,010 BASIC CH.	-386,783
3020		1	BASIC CHARGE-IPA	-1,466,563		0	0	0	0		3,020	3,020 BASIC CH.	-1,466,563
3030		1	BASIC CHARGE-MEDICARE	-651,182		0	0	0	0		3,030	3,030 BASIC CH.	-651,182
3035		4	DAY CARE/HOME CARE			0	0	0	0		3,040		
3040		1	LIGHT NURSING CARE	61		0	0	0	0		3,050	3,050 MEDIUM N	61
3050		1	MEDIUM NURSING CARE			0	0	0	0		3,060		
3060		1	HEAVY NURSING CARE			0	0	0	0		3,061		
3061		1	SKILLED NURSING CARE								3,080	3,080 NURSING	-12,793
3080		1	NURSING SUPPLIES-PRIVATE	-119,316		0	0	0	0		3,081	3,081 NURSING	-85,088
3081		1	NURSING SUPPLIES-IPA			0	0	0	0		3,082	3,082 NURSING	-14,039
3082		1	NURSING SUPPLIES MED PT A			0	0	0	0		3,083	3,083 NURSING	-7,396
3083		1	NURSING SUPPLIES MED PT B								3,100	3,100 DRUGS-MI	-135,862
3100		17	DRUGS	-235,748		0	0	0	0		3,101	3,101 DRUGS-OT	-99,886
3101		17	DRUGS-OTHER								3,110	3,110 PHYSICAL	-27,754
3110		6	PT-PRIVATE	-234,719		0	0	0	0		3,111	3,111 PHYSICAL	-25
3111		6	PT-IPA			0	0	0	0		3,112	3,112 PHYSICAL	-97,640
3112		6	PT-MEDICARE PART A			0	0	0	0		3,113	3,113 PHYSICAL	-9,075
3113		6	PT-MEDICARE PART B			0	0	0	0		3,140	3,140 LABORAT	-9,302
3130		1	PUBLIC AID ASSESSMENT INC								3,150	3,150 ST/OT THE	-8,080
3140		19	LABORATORY INCOME			0	0	0	0		3,151	3,151 ST/OT THE	-207
3150		6	SPEECH/OT-PRIVATE			0	0	0	0		3,152	3,152 ST/OT THE	-75,500
3151		6	SPEECH/OT-IPA			0	0	0	0		3,153	3,153 ST/OT THE	-7,136
3152		6	SPEECH/OT-MED PART A			0	0	0	0		3,160		
3153		6	SPEECH/OT MED PART B								3,410	3,410 IPA/OTHE	155,146
3410		2	IPA DISCOUNTS	501,372		0	0	0	0		3,411	3,411 MEDICAR	8,413
3411		2	MEDICAID PART B DISCOUNT			0	0	0	0		3,420	3,420 MEDICAR	332,343
3420		2	MEDICARE DISCOUNTS			0	0	0	0		3,500		
3440		36	ASSESSMENT TAX EXPENSE			42	3	0	0		3,520		
3520		16	RENT INCOME	0		6	0	6	0		3,530	3,530 BEAUTY S	-6,774
3530		13	BEAUTY SHOP	-6,774		0	0	0	0		3,560	3,560 ACTIVITY	-550
3560		12	ACTIVITY FUND INCOME	-550		0	0	0	0		3,570	3,570 VENDING	-1,140
3570		12	VENDING INCOME/EXPENSE	-1,140		0	0	0	0		3,590	3,590 EQUIPMEN	-13,981
3580		12	MANAGEMENT FEES			0	0	0	0		3,595		
3590		1	EQUIPMENT RENTAL	-13,981		0	0	0	0		3,600	3,600 MISC INC	-244
3595		21	RESIDENT TRANSPORTATION	0		0	0	0	0		4,110	4,110 G&A WAG	66,393
3600		21	MISC INCOME	-244		0	0	0	0		4,111	4,111 ADMINIST	53,000
4110			GENERAL & ADMINIST WAGES	66,393	70,741	21	1	17	0		4,115	4,115 G&A PTO	4,348
4111			ADMINISTRATOR WAGES	53,000	53,000	17	1	0	0		4,120	4,120 EMPLOYE	4,200
4115			VACATION & SICK - G&A	4,348		21	1	0	0		4,125	4,121 PENSION I	426
4120	4475		EMPLOYEE BENEFITS	4,284	191,504	22	3	0	0		4,130	4,130 EMPLOYE	3,107
4125			EMPLOYEE HEPETITIS VACCIN	426		22	3	0	0		4,135	4,135 EMPLOYE	492
4130			EMPLOYEE SCHOLORSHIP WA	3,107		21	1	0	0		4,250	4,250 OFFICE SU	6,067
4135			EMPLOYEE SCHOLORSHIP COS	492		23	3	0	0		4,255	4,255 POSTAGE	1,867
4220			DIRECTORS FEES			18	3	0	0		4,260	4,260 TELEPHO	13,368
4250	4255		OFFICE SUPPLIES	8,690	8,690	21	2	0	0		4,275	4,275 TRAINING	1,425
4260			TELEPHONE	13,368	13,368	21	3	0	0		4,276	4,276 INJURY PI	231
4275			TRAINING & EMPLOYEE DEVL	1,425	1,425	23	3	16	0		4,280	4,280 GENERAL	4,925
4280			GENERAL TRAVEL	4,925	6,432	24	3	16	0		4,281	4,281 MEAL EXI	133
4281			MEAL EXPENSE FOR TRAVEL	133		24	3	19	0		4,285	4,285 EDUCATIO	1,251
4285			EDUCATION & SEMINAR	1,374		24	3	19	-8,897 ***		4,289	4,289 MEETINGS	123
4290			HELP WANTED ADVERTISING	13,218	67,463	20	3	0	0	-41,062	4,290	4,290 HELP WA	13,218
4291			PROMOTIONAL ADVERTISING	3,610		20	3	25	-3,610		4,291	4,291 PROMOTIO	3,610
4292			PUBLIC RELATIONS	2,819		20	3	25	-2,819		4,292	4,292 PUBLIC RI	2,819
4300			LICENSES & FEES	41,773		20	3	17	0		4,300	4,300 LICENSE	41,773
4310			DUES & SUBSCRIPTIONS	5,679		20	3	17	-360		4,310	4,310 DUES & SU	5,679
4320			CONTRIBUTIONS	25		27	3	20	-25		4,320	4,320 CONTRIBU	25
4350			PROFESSIONAL FEES	6,676	169,938	19	3	22	-6,676		4,350	4,350 PROFESSI	6,676
4355			MEDICAL DIRECTOR	19,500	19,500	9	3	0	0		4,355	4,355 MEDICAL	19,500
4360			UTILIZATION REVIEW	0		10	3	0	0		4,362	4,362 MEDICAL	1,400
4361			OTHER PHYSICIAN FEES	0		39	3	0	0		4,363	4,363 PHARMAC	2,040
4362			MEDICAL RECORDS CONSULT	1,400		10	3	0	0		4,364	4,364 SOCIAL SE	2,374
4363			PHARMACIST FEES	2,040		10	3	0	0		4,370	4,370 TV RENTA	1,585
4364			SOC SERV/ACT CONSULT	2,374	2,374	12	3	0	0		4,383	4,383 BACKGRO	364
4370			TV RENTAL	1,585		35	3	5	-1,173 **		4,390		
4380			INCOME TAXES	0	36,361	27	3	26	0		4,400	4,400 PAYROLL	103,024
4383			BACKGROUND CHECKS	364		20	3	26	0		4,401	4,401 PAYROLL	5,501
4400			PAYROLL TAXES	103,024		22	3	0	0		4,410	4,410 GROUP IN	50,424
4401			PAYROLL TAXES ADMINIST	5,501		22	3	0	0		4,420	4,420 LIABILITY	28,431
4410			GROUP INSURANCE	50,424		22	3	0	0		4,430	4,430 WORKMA	16,172
4420			LIABILITY INSURANCE	28,431	28,431	26	3	0	0		4,435	4,435 W/C-FIRST	7,150
4425			INSURANCE-OWNERS			22	3	21	0		4,436	4,436 DRUG TES	693
4430			WORKMENS COMP INSURANCI	24,246		22	3	0	0		4,450	4,450 CENTRAL	163,262
4450			CENTRAL OFFICE FEES	163,262		19	3	34	-163,262		4,460	4,460 BAD DEBT	36,000
4460			BAD DEBTS	36,000		27	3	24	-36,000		4,461	4,461 BAD DEBT	5,470
4470			LOST ITEMS-RESIDENTS	336		27	3	0			4,470	4,470 LOST ITEM	336
4490			MISCELLANEOUS	0		27	3	0	0		4,475	4,475 UNIFORM	84
4510			REAL ESTATE TAXES	58,000	58,000	33	3	0	0		4,486	4,486 SERVICE	4,214
4600			LEASED EQUIPMENT	4,356	5,941	35	3	16	0		4,490	4,490 MISC EXP	-752
5110			MAINTENANCE SALARIES	27,681	29,292	6	1	0	0		4,496	4,496 MISC. M.I.	756
5120			MAINTENANCE SICK & VAC	1,611		6	1	0	0		4,510	4,510 REAL EST.	58,000
5130			ELECTRIC	61,721	78,666	5	3	0	0		4,600	4,600 LEASED E	4,356
5131			NATURAL GAS	0		5	3	0	0		5,110	5,110 MAINTEN	27,681
5132			HEATING & DEISEL OIL			5	3	0	0		5,120	5,120 MAINTEN	1,611
5133			WATER & SEWER	16,945		5	3	0	0		5,130	5,130 ELECTRIC	61,721
5134			TRASH COLLECTION	2,128	12,894	6	3	0	0		5,131		
5140			PROPERTY PLANT REPLACEM	10,473	25,051	6	2	0	0		5,133	5,133 WATER &	16,945
5160			GENERAL REPAIR & MAINT	14,578		6	2	0	0		5,134	5,134 TRASH CO	2,128
5165			MAINTENANCE CONTRACTS	10,766		6	3	0	0		5,140	5,140 PROP/PLA	10,473
5210			DIETARY WAGES	127,403	133,930	1	1	0	0		5,160	5,160 GENERAL	14,578
5220			DIETARY SICK & VAC	6,527		1	1	0	0		5,165	5,165 MAINTEN	6,552
5240			SALES TAX			2	3	13	-857		5,210	5,210 DIETARY	127,403
5248			FOOD PURCHASES	104,975	104,662	2	2	0	0		5,220	5,220 DIETARY	6,527
5250			SUPPLIES-DISHWASHING	4,308	11,987	1	2	0	0		5,248	5,248 FOOD PUR	105,727
5260			DIETARY REPLACEMENT	1,107		1	2	0	0		5,250	5,250 SUPPLIES	4,308
5270			KITCHEN SUPPLIES-PAPER	6,572		1	2	0	0		5,260	5,260 REPLACE	1,107
5295			MEAL CREDIT	-313		2	2	0	0		5,270	5,270 KITCHEN	6,572
5310			LAUNDRY WAGES	24,345	25,912	4	1	0	0		5,295	5,295 MEAL INC	-313
5340			LAUNDRY SICK & VAC	1,567		4	1	0	0		5,310	5,310 LAUNDRY	24,345
5370			LAUNDRY REPLACEMENT	3,767	9,799	4	2	0	0		5,340	5,340 LAUNDRY	1,567
5380			LAUNDRY REIMBURSEMENT			4	3	0	0		5,370	5,370 REPLACE	3,767
5390			LAUNDRY SUPPLIES	6,032		4	2	0	0		5,380	5,380 OUTSIDE I	56
5410			HOUSEKEEPING WAGES	62,377	65,816	3	1	0	0		5,390	5,390 SUPPLIES	5,976
5440			HOUSEKEEPING SICK & VAC	3,439		3	1	0	0		5,410	5,410 HOUSEKE	62,377
5480			HOUSEKEEPING SUPPLIES	1,893	9,469	3	2	0	0		5,440	5,440 HOUSEKE	3,439
5490			HOUSEKEEPING SUPPLIES-PPR	7,576		3	2	0	0		5,480	5,480 SUPPLIES-	1,893
6010			RN WAGES-MEDICARE		795,826	10	1	0	0		5,490	5,490 SUPPLIES-	7,576
6020			RN WAGES-NON MEDICARE	109,435		10	1	0	0		6,020	6,020 RN WAGE	109,435
6030			DON WAGES	38,572		10	1	0	0		6,030	6,030 DON WAG	38,572
6035			ADON	0		10	1	0	0		6,035		
6040			RN SICK & VACATION	7,916		10	1	0	0		6,040	6,040 RN PTO &	7,916
6110			LPN WAGES-MEDICARE			10	1	0	0		6,120	6,120 LPN WAGI	181,903
6120			LPN WAGES-NON MEDICARE	181,903		10	1	0	0		6,140	6,140 LPN PTO &	10,799
6130			LPN WAGES OTHER			10	1	0	0		6,220	6,220 AIDES WA	361,569
6140			LPN SICK & VACATION	10,799		10	1	0	0		6,240	6,240 AIDES PTO	26,254
6210			AIDE WAGES-MEDICARE			10	1	0	0		6,245	6,245 CONTRAC	5,007
6220			AIDE WAGES-NON MEDICARE	361,569		10	1	0	0		6,246	6,246 CONTRAC	38,753
6230			WARD CLERKS			10	1	0	0		6,247	6,247 CONTRAC	112,253
6240			AIDE VACATION & SICK	26,254		10	1	0	0		6,250	6,250 NURSE AI	2,349
6245			CONTRACT NURSES-RN	5,007		10	3	0	0		6,255	6,255 NURSE AI	798
6246			CONTRACT NURSES-LPN	38,753		10	3	0	0		6,260	6,270 REHAB W.	0
6247			CONTRACT NURSES-AIDES	112,253		10	3	0	0		6,270	6,275 REHAB PT	55,977
6250			NURSE AIDE TRAINING WAGES	2,349	2,349	13	1	0	0		6,275	6,279 REHAB TI	3,401
6255			NURSE AID TRAINING EXP	798	798	13	2	0	0		6,290	6,290 NURSING	53,248
6260			NURSE AIDE TRAINING REIMB	0		0	0	0	0		6,295	6,295 NURSING	10,305
6270			REHAB WAGES	55,977		10	1	0	0		6,390	6,390 REPLACE	1,850
6275			REHAB SICK & VAC	3,401		10	1	0	0		6,490	6,490 OTHER	269
6280			NURSING DEPT EDUCATION			23	3	0	0		7,280	7,280 DRUG PUI	75,904
6290			NURSING SUPPLIES	53,248	65,403	10	2	0	0		7,281	7,281 DRUG PUI	59,437
6295			NURSING SUPPLIES	10,305		10	2	0	0		7,380	7,380 LABORAT	307
6390			REPLACEMENT-NURSING	1,850		10	2	0	0		7,391	7,391 AMBULAN	33
6490			NURSING OTHER	269	159,722	10	3	0	0		7,393	7,393 OTHER A	224
7280			DRUG PURCHASES	75,904	137,223	39	2	0	147,851 ***		7,510	7,510 ACTIVITIE	18,617
7281			DRUG PURCHASES-OTHER	59,437		39	2				7,540	7,540 ACTIVITIE	343
7380			LABORATORY SERVICES	564	123,148	39	3	0	0		7,590	7,590 ACTIVITIE	1,767
7410			HOME HEALTH SALARY			39	1	0	0		7,620	7,620 PHYSICAL	68,152
7440			HOME HEALTH SICK & VAC			39	1	0	0		7,660	7,660 P.T. SUPPI	1,882
7450			HOME HEALTH EXPENSES			39	3	0	0		7,710	7,710 SOCIAL SE	20,792
7510			ACTIVITES WAGES	18,617	18,960	11	1	0	0		7,720	7,720 SOCIAL SE	130
7540			ACTIVITIES SICK & VAC	343		11	1	0	0		7,730		
7590			ACTIVITIES SUPPLIES	1,767	1,767	11	2	0	0		7,740	7,740 OCCUPAT	50,428
7595			ACTIVITIES FEES	0	0	11	3	0	0		7,750		
7610			PT WAGES			39	1	0	0		7,770	7,770 SPEECH T	4,004
7611			PT SICK & VACATION			39	1	0	0		7,820	7,820 BEAUTICI	7,311
7620			PT FEES	68,152		39	3	0	-11,793 ***		7,890		
7660			PT SUPPLIES	1,882		39	2	0	0		7,960		
7710			SOCIAL SERVICE WAGES	20,792	20,922	12	1	0	0		8,120	8,120 INTEREST	116,067
7720			SOCIAL SERVICE SICK & VAC	130		12	1	0	0		8,125	8,125 ALLOCAT	12,484
7730			SOCIAL SERVICE EXPENSES	0	0	12	2	0	0		8,130	8,130 DEPRECIA	192,403
7740			OT FEE	50,428		39	3	0	-5,839 ***		8,150	8,150 LOAN FEE	4,571
7750			SOCIAL THERAPIST FEE	0	0	12	3	0	0		9,510	9,510 INTEREST	-529
7770			SPEECH THERAPY FEE	4,004		39	3	0	3,529 ***		9,520		
7800			BEAUTICIAN WAGES		0	40	1	0	0		9,530	8,100 RENT EXP	396
7810			BEAUTICIAN SICK & VAC			40	1	0	0				
7820			BEAUTICIAN FEES	7,311	7,311	40	3	0	0				
7890			BEAUTY SHOP SUPPLIES	0	0	40	2	0	0				
7910			VOLUNTEER COORDINATOR	0	0	21	1	0	0				
7940			VOL COORD SICK & VAC			21	1	0	0				
7960			VOL COORD SUPPLIES	0		21	2	0	0				
8100			RENT	396	396	34	3	0	0				283,900
8120			INTEREST EXPENSE	128,551	133,122	32	3	14	-529				
8130			DEPRECIATION	192,403	192,403	30	3	9	0				
8150			LOAN FEE AMORTIZATION	4,571		32	3	0	0	60,773			
9510			INTEREST INCOME	-529		32	0	10	0				
9520			MISC NON-OPERATING INCOM	0		0	0	0	0				
9700			INCOME TAXES			0	0	0	0				
				2,899,467	2,899,996								
					529								
GRAND TOTALS				283,900					-90,460				
				(NET INCOME)									
				0									
			FACILITY NAME:										
			FACILITY ID:	0									
			FACILITY UNITS:	89									
			BALANCE SHEET TOTAL	0									
				173,113									

	G/L	RECAP CENSUS
PP	3,496	3,313
IPA	16,937	16,930
medicare	2,568	2,568
	23,001	22,811
IPA BEDHOLDS	7	
PP BEDHOLDS	183	
PP CONVERS	0	